Complaint Form

The Mississippi State Department Of Health (MSDH) will not engage in any intimidation or retaliatory act against persons filing complaints or exercising their rights under HIPAA regulation. Complaints will not affect services provided.

Print Name: _____ Phone: (_____) _____

Mailing Address: _____ (City) _____ (State) _____ (Zip) _____

Identify facility associated with complaint: _____

Describe Complaint: Include names of any persons involved, location, and date of incident **(Attach additional pages, if needed):**

_____

_____

_____

_____

_____

_____

Signature_____ Date: _____

Agency Response

Response:_____

_____

_____

_____

_____

Additional pages attached: ☐ Yes Number of pages: _____

Print Name: _____ Title: _____

Signature:_____ Date:_____

District Reviewing Officer (Attach comments, if needed)

Print Name: _____Title: _____

Signature: _____ Date: _____

Keep gold copy for your records and mail the remaining copies to: **Organizational Quality**
Post Office Box 1700
Jackson, Mississippi 39215-1700